

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040493</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Fairmont Care Centre</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>5061 N. Pulaski Road</u> <u>Chicago</u> <u>60630</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) <u>28-March-2003</u> (Type or Print Name) <u>Christopher Vicere</u> (Title) <u>Vice President - Finance</u>	
Telephone Number: <u>(773) 604-8112</u> Fax # <u>(773) 604-8113</u>		Paid Preparer (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>36-3980966</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>11-May-1995</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Christopher Vicere</u> Telephone Number: <u>(773) 604-4416</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Fairmont Care Centre# 0040493 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>94</u>	Skilled (SNF)	<u>94</u>	<u>34,310</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>72</u>	Intermediate (ICF)	<u>72</u>	<u>26,280</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>166</u>	TOTALS	<u>166</u>	<u>60,590</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,624</u>	<u>3,138</u>	<u>5,080</u>	<u>13,842</u>	8
9	SNF/PED					9
10	ICF	<u>39,139</u>	<u>2,840</u>		<u>41,979</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>44,763</u>	<u>5,978</u>	<u>5,080</u>	<u>55,821</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.13%

D. How many bed-hold days during this year were paid by Public Aid?

462 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11-May-1995

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11-May-1995 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 94 and days of care provided 5,006Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	318,103	42,138	12,915	373,156		373,156		373,156			1
2	Food Purchase		284,850		284,850	(19,134)	265,716	(268)	265,448			2
3	Housekeeping	235,493	26,770		262,263		262,263		262,263			3
4	Laundry	72,407	39,955	32,382	144,744		144,744		144,744			4
5	Heat and Other Utilities			212,883	212,883		212,883		212,883			5
6	Maintenance	78,007	30,656	105,837	214,500		214,500	13,280	227,780			6
7	Other (specify):*											7
8	TOTAL General Services	704,010	424,369	364,017	1,492,396	(19,134)	1,473,262	13,012	1,486,274			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,466,173	204,590	7,632	2,678,395		2,678,395		2,678,395			10
10a	Therapy			11,361	11,361		11,361		11,361			10a
11	Activities	149,653	14,646	900	165,199		165,199		165,199			11
12	Social Services	101,788		2,414	104,202		104,202		104,202			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **Dental Services**			1,125	1,125		1,125		1,125			15
16	TOTAL Health Care and Programs	2,717,614	219,236	41,432	2,978,282		2,978,282		2,978,282			16
	C. General Administration											
17	Administrative	74,863		199,200	274,063		274,063	(159,832)	114,231			17
18	Directors Fees											18
19	Professional Services			25,235	25,235		25,235	10,803	36,038			19
20	Dues, Fees, Subscriptions & Promotions			24,530	24,530		24,530	15,858	40,388			20
21	Clerical & General Office Expenses	144,985	42,343	68,697	256,025		256,025	41,450	297,475			21
22	Employee Benefits & Payroll Taxes			558,887	558,887	19,134	578,021	23,099	601,120			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,472	2,472		2,472	6,472	8,944			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			55,710	55,710		55,710		55,710			26
27	Other (specify):*							9,537	9,537			27
28	TOTAL General Administration	219,848	42,343	934,731	1,196,922	19,134	1,216,056	(52,613)	1,163,443			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,641,472	685,948	1,340,180	5,667,600		5,667,600	(39,601)	5,627,999			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Fairmont Care Centre

#0040493

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			126,462	126,462		126,462	494,816	621,278			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			400,000	400,000		400,000	401,436	801,436			32
33	Real Estate Taxes			189,387	189,387		189,387		189,387			33
34	Rent-Facility & Grounds			1,440,000	1,440,000		1,440,000	(1,440,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			2,155,849	2,155,849		2,155,849	(543,748)	1,612,101			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		173,223	210,740	383,963		383,963		383,963			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			90,885	90,885		90,885		90,885			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		173,223	301,625	474,848		474,848		474,848			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,641,472	859,171	3,797,654	8,298,297		8,298,297	(583,349)	7,714,948			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(640,513)	30		9
10	Interest and Other Investment Income	(81,734)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(268)	2		13
14	Non-Care Related Interest	2,771	32		14
15	Non-Care Related Owner's Transactions	(4,608)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(37,666)	21		24
25	Fund Raising, Advertising and Promotional	(14,992)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,731)	20		28
29	Other-Attach Schedule <u>**Deferred Maintenance Cost**</u>	12,135	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (767,006)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	183,657	6 & 6A	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 183,657		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (583,349)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Fairmont Care Centre

ID# 0040493

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	**Deferred Maintenance Cost**	\$ 12,135	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	12,135		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(268)	0	0	0	0	0	0	0	0	0	0	(268)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	12,135	1,145	0	0	0	0	0	0	0	0	0	13,280	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	11,867	1,145	0	0	0	0	0	0	0	0	0	13,012	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(159,832)	0	0	0	0	0	0	0	0	0	(159,832)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,803	0	0	0	0	0	0	0	0	0	10,803	19
20	Fees, Subscriptions & Promotions	(17,123)	32,981	0	0	0	0	0	0	0	0	0	15,858	20
21	Clerical & General Office Expenses	(37,666)	79,116	0	0	0	0	0	0	0	0	0	41,450	21
22	Employee Benefits & Payroll Taxes	0	23,099	0	0	0	0	0	0	0	0	0	23,099	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,472	0	0	0	0	0	0	0	0	0	6,472	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	9,537	0	0	0	0	0	0	0	0	0	9,537	27
28	TOTAL General Administration	(54,789)	2,176	0	0	0	0	0	0	0	0	0	(52,613)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,922)	3,321	0	0	0	0	0	0	0	0	0	(39,601)	29

Summary B

12/31/2002

[illegible]

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Officers' Salaries	\$	Lancaster, Ltd.	100.00%	\$ 36,740	\$ 36,740 1
2	V	27 Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	1,877	1,877 2
3	V	17 Management Fee Income	199,200	Lancaster, Ltd.	100.00%		(199,200) 3
4	V	19 Professional Services		Lancaster, Ltd.	100.00%	10,803	10,803 4
5	V	21 Clerical Expenses		Lancaster, Ltd.	100.00%	79,116	79,116 5
6	V	22 Employee Benefits		Lancaster, Ltd.	100.00%	23,099	23,099 6
7	V	24 Education, Travel & Seminars		Lancaster, Ltd.	100.00%	6,472	6,472 7
8	V	17 Administrative Consultant		Lancaster, Ltd.	100.00%	2,628	2,628 8
9	V	20 Fees and Marketing		Lancaster, Ltd.	100.00%	32,981	32,981 9
10	V	32 Interest		Lancaster, Ltd.	100.00%	23,017	23,017 10
11	V	30 Depreciation		Lancaster, Ltd.	100.00%	1,619	1,619 11
12	V	6 Maintenance		Lancaster, Ltd.	100.00%	1,145	1,145 12
13	V	27 Payroll Taxes - Clerical		Lancaster, Ltd.	100.00%	7,660	7,660 13
14	Total		\$ 199,200			\$ 227,157	\$ * 27,957 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34 Rental	\$ 1,440,000	Fairmont Property, LLC		\$	\$ (1,440,000)	15
16	V	32 Interest	7,650	Fairmont Property, LLC		467,803	460,153	16
17	V	32 Non-Care related interest	2,771	Fairmont Property, LLC			(2,771)	17
18	V	30 Depreciation		Fairmont Property, LLC		1,138,318	1,138,318	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,450,421			\$ 1,606,121	\$ * 155,700	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Fairmont Care Centre # 0040493 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Laurence Zung	Executive Officer	Administrative	42.5%	see attached	2	4.17%	Lancaster	\$ 14,679	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	10.00%	see attached	5	10.42%	Lancaster	31,214	21-1 & 17-7	2
3	Cheryl Morris	VP-Operations	Administrative	5.00%	see attached	5	10.42%	Lancaster	9,155	17-7	3
4	Julie T. Chow (eff. Apr '02)	Administrator	Administrative	0%	See * below	40	100.00%	Reg. Salary	46,852	17-1	4
5											5
6											6
7											7
8											8
9			* Julie Chow received salary of \$ 15,987 from Lakeshore Health & Rehab. Centre								9
10			for the period Jan to Apr. '02 while she worked there as Asst. Administrator.								10
11											11
12											12
13								TOTAL	\$ 101,900		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Fairmont Care Centre# 0040493

Report Period Beginning:

01/01/2002Ending: 12/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Lancaster, Ltd.Street Address 5061 N. Pulaski RoadCity / State / Zip Code Chicago, IL 60630Phone Number (773) 478-3699Fax Number (773) 478-1192

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Laurence Zung	Hours Worked	48	7	\$ 352,300	\$ 352,300	2	\$ 14,679	1
2	27 Laurence Zung	Hours Worked	48	7	10,482	0	2	437	2
3	17 Christopher Vicere	Hours Worked	48	7	123,902	123,902	5	12,906	3
4	27 Christopher Vicere	Hours Worked	48	7	7,171	0	5	747	4
5	17 Cheryl Morris	Hours Worked	48	7	87,889	87,889	5	9,155	5
6	27 Cheryl Morris	Hours Worked	48	7	6,648	0	5	693	6
7									7
8									8
9	19 Professional Services	Management Fees	1,611,600	7	87,404		199,200	10,803	9
10	21 Clerical Expenses	Management Fees	1,611,600	7	35,722		199,200	4,415	10
11	22 Employee Benefits	Management Fees	1,611,600	7	186,880		199,200	23,099	11
12	24 Education and Seminars	Management Fees	1,611,600	7	11,327		199,200	1,400	12
13	17 Administrative Consultant	Management Fees	1,611,600	7	21,265		199,200	2,628	13
14	20 Marketing	Management Fees	1,611,600	7	251,556	174,958	199,200	31,093	14
15	32 Interest	Management Fees	1,611,600	7	11,616		199,200	1,436	15
16	30 Depreciation	Management Fees	1,611,600	7	13,099		199,200	1,619	16
17	20 Licenses and Fees	Management Fees	1,611,600	7	15,277		199,200	1,888	17
18	6 Maintenance	Management Fees	1,611,600	7	9,263		199,200	1,145	18
19	24 Travel	Management Fees	1,611,600	7	41,037		199,200	5,072	19
20	21 Salaries-Clerical	Management Fees	1,611,600	7	604,357	604,357	199,200	74,701	20
21	27 Payroll Taxes-Clerical	Management Fees	1,611,600	7	61,975		199,200	7,660	21
22									22
23	32 Direct Interest							21,581	23
24									24
25	TOTALS				\$ 1,939,170	\$ 1,343,406		\$ 227,157	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Harston Investments		X				\$	\$			\$	800,000	1
2													2
3													3
4													4
5													5
	Working Capital												
6	American National (Bank One)		X									1,436	6
7													7
8													8
9	TOTAL Facility Related						\$	\$			\$	801,436	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$		14
15	TOTALS (line 9+line14)						\$	\$			\$	801,436	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Fairmont Care Centre

0040493 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	183,979	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	185,366	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,387	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	188,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	189,387	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997 159,194 8			
		1998 162,020 9			
		1999 178,617 10			
		2000 180,668 11			
		2001 185,366 12			
			FOR OHF USE ONLY		
			13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
			14	PLUS APPEAL COST FROM LINE 5 \$	14
			15	LESS REFUND FROM LINE 6 \$	15
			16	AMOUNT TO USE FOR RATE CALCULATION \$	16
** Accrual is based on 2001 actual Taxes, adjusted for inflation**					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairmont Care Centre COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040493

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-300-009-0000</u>	<u>Long-Term Healthcare</u>	\$ <u>185,366.28</u>	\$ <u>185,366.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>185,366.28</u>	\$ <u>185,366.28</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 108,681

B. General Construction Type: Exterior Brick Frame

Number of Stories

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Care Facility	218,869	1995	\$ 685,000	1
2					2
3	TOTALS	218,869		\$ 685,000	3

Facility Name & ID Number Fairmont Care Centre

0040493

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	166	1995		\$ 2,240,980	\$ 57,461	20	\$ 112,049	\$ 54,588	\$ 869,497
5									
6									
7									
8									
Improvement Type**									
9	Canopy and Awning	1995		3,300	85	20	165	80	1,265
10	Intercom System	1995		1,844	47	20	92	45	678
11	Roof Exhausters	1996		2,136	55	20	105	50	676
12	Permanent Signage	1997		16,625	1,074	15	1,661	587	8,590
13	Fire Alarm	1997		68,600	1,759	20	3,430	1,671	18,008
14	Parking Lot Excavation	1997		45,000	2,906	15	4,500	1,594	23,625
15	Parking Lot Asphalt	1997		68,000	4,392	15	3,400	(992)	17,850
16	Concrete Curbs	1997		18,000	1,163	15	900	(263)	4,725
17	Phase I Expansion-Landscaping	1997		41,000	2,648	15	2,050	(598)	10,763
18	Site Sewer	1997		28,500	1,841	15	1,425	(416)	7,481
19	Phase I Expansion-Building	1997		1,218,394	345,690	20	108,562	(237,128)	367,472
20	Ceramic Tiled Hallway	1998		10,603	272	15	530	258	2,473
21	Electrical Enhancements	1998		6,210	159	15	309	150	1,449
22	Phase II-Landscape	1999		15,000	1,154	15	1,154		4,612
23	Site Sewer	1999		40,376	3,107	15	3,107		12,414
24	Fire Protection	1999		43,440	1,114	20	1,114		3,667
25	Excavation	1999		49,650	3,821	15	3,821		15,266
26	Phase II Expansion	1999		2,281,933	683,019	20	216,979	(466,040)	351,067
27	Electrical-Courtyard	2001		6,520	167	15	167		327
28	Building Roofing	2001		21,919	562	20	562		679
29	Garage Roofing	2001		7,500	192	20	192		232
30	Heating System	2001		17,965	461	15	461		557
31	Addition to Heating System	2002		8,561	2,600	20	214	(2,386)	214
32	Improvement to Heating System	2002		11,688	3,533	20	195	(3,338)	195
33	Parking Lot Expansion	2002		31,500	9,521	20	525	(8,996)	525
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,305,244	\$ 1,128,803		\$ 467,669	\$ (661,134)	\$ 1,724,307	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,388,014	\$ 113,846	\$ 72,129	\$ (41,717)		\$ 942,105	71
72	Current Year Purchases	44,653	19,142	3,521	(15,621)		3,521	72
73	Fully Depreciated Assets	39,847		77,959	77,959		39,847	73
74								74
75	TOTALS	\$ 1,472,514	\$ 132,988	\$ 153,609	\$ 20,621		\$ 985,473	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,462,758	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,261,791	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 621,278	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (640,513)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,709,780	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Rental Property	\$ 179,744	\$ 4,608	\$ 35,086	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 179,744	\$ 4,608	\$ 35,086	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: *** Fairmont Property,Llc (a related entity)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ None Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	\$	\$		\$	
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
					Units	Cost									
1	Licensed Occupational Therapist	39-3	hrs	\$		\$	87,935	\$		\$	87,935	1			
2	Licensed Speech and Language Development Therapist	39-3	hrs				6,310				6,310	2			
3	Licensed Recreational Therapist		hrs									3			
4	Licensed Physical Therapist	39-3	hrs				107,026				107,026	4			
5	Physician Care		visits									5			
6	Dental Care		visits									6			
7	Work Related Program		hrs									7			
8	Habilitation		hrs									8			
9	Pharmacy	39-2	# of prescrpts					120,086			120,086	9			
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10			
11	Academic Education		hrs									11			
12	Exceptional Care Program	39-3					9,469				9,469	12			
	Medical Supplies	39-2						14,763			14,763				
13	Other (specify): Rental Specialty Beds	39-2						38,374			38,374	13			
14	TOTAL			\$		\$	210,740	\$	173,223	\$	383,963	14			

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 141,511	\$ 143,013	1
2	Cash-Patient Deposits	58,234	58,234	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,230,272	1,230,272	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,738	43,738	6
7	Other Prepaid Expenses	1,215	1,215	7
8	Accounts Receivable (owners or related parties)	3,576,147	149,132	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,051,117	\$ 1,625,604	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		685,000	13
14	Buildings, at Historical Cost		2,420,724	14
15	Leasehold Improvements, at Historical Cost	563,937	3,794,963	15
16	Equipment, at Historical Cost	1,081,503	1,209,689	16
17	Accumulated Depreciation (book methods)	(1,155,672)	(2,710,439)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	67,109	67,109	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(67,109)	(67,109)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 489,768	\$ 5,399,937	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,540,885	\$ 7,025,541	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 155,166	\$ 155,166	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	58,234	58,234	28
29	Short-Term Notes Payable	4,031,809	7,849,061	29
30	Accrued Salaries Payable	347,550	347,550	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,982	9,982	31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,000	188,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,790,741	\$ 8,607,993	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,790,741	\$ 8,607,993	46
47	TOTAL EQUITY(page 18, line 24)	\$ 750,144	\$ (1,582,452)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,540,885	\$ 7,025,541	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,101,835	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,101,835	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	648,309	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Capital Contributions**		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (351,691)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 750,144	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairmont Care Centre

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Report Period Beginning: 01/01/2002

Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		Total After Consolidation	
1	Balance at Beginning of Year, as Previously Reported	\$ (75,061)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (75,061)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	492,609	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,000,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,507,391)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,582,452)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,708,722	1
2	Discounts and Allowances for all Levels	(943,220)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,765,502	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	780,625	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 780,625	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,874	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,853	19
20	Radiology and X-Ray	5,660	20
21	Other Medical Services	46,939	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 151,326	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	81,734	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 81,734	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental Income	167,419	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 167,419	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,946,606	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,492,396	31
32	Health Care	2,978,282	32
33	General Administration	1,196,922	33
	B. Capital Expense		
34	Ownership	2,155,849	34
	C. Ancillary Expense		
35	Special Cost Centers	383,963	35
36	Provider Participation Fee	90,885	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,298,297	40
41	Income before Income Taxes (line 30 minus line 40)**	648,309	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 648,309	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. ***Cash Basis Taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Fairmont Care Centre

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Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,037	2,078	\$ 65,956	\$ 31.74	1
2	Assistant Director of Nursing	1,607	1,933	49,024	25.36	2
3	Registered Nurses	46,627	49,948	1,155,074	23.13	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	106,109	114,211	1,131,170	9.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,983	2,206	43,464	19.70	9
10	Activity Assistants	10,218	10,906	106,189	9.74	10
11	Social Service Workers	7,846	8,239	101,788	12.35	11
12	Dietician					12
13	Food Service Supervisor	1,974	2,085	28,916	13.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,984	35,234	289,187	8.21	15
16	Dishwashers					16
17	Maintenance Workers	5,537	5,935	78,007	13.14	17
18	Housekeepers	26,231	28,193	235,493	8.35	18
19	Laundry	8,664	9,081	72,407	7.97	19
20	Administrator	1,807	2,180	74,863	34.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,524	10,233	144,985	14.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,990	4,358	64,949	14.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	267,138	286,820	\$ 3,641,472 *	\$ 12.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	258	\$ 12,915	1-3	35
36	Medical Director	900	18,000	9-3	36
37	Medical Records Consultant	103	4,128	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	340	3,504	10-3	39
40	Physical Therapy Consultant	344	11,361	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	900	11-3	44
45	Social Service Consultant	52	2,414	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,021	\$ 53,222		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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Report Period Beginning: 01/01/2002

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership		D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description	Amount	Description	Amount	
Nancy Elwart (upto Apr. '02)	Administrator	N/A	\$ 27,143	Workers' Compensation Insurance	\$ 36,081	IDPH License Fee	\$ 400	
Julie T. Chow (eff. Apr'02)	Administrator	N/A	47,720	Unemployment Compensation Insurance	19,008	Advertising: Employee Recruitment	23	
				FICA Taxes	268,591	Health Care Worker Background Check		
				Employee Health Insurance	187,038	(Indicate # of checks performed <u>153</u>)	1,836	
				Employee Meals	19,134	**Licenses & Fees**	4,043	
				Illinois Municipal Retirement Fund (IMRF)*		**Promotional Advertising**	16,723	
				Miscellaneous Employee Benefits	21,576	**Dues & Subscriptions**	1,105	
				Uniform Allowance	1,815	**Charitable Contributions**	400	
				Retirement Plan Contribution	14,146	**Lancaster Allocation**	32,981	
				Dental Insurance	10,632			
				Lancaster Allocation	23,099	Less: Public Relations Expense	(400)	
						Non-allowable advertising	(14,992)	
						Yellow page advertising	(1,731)	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 74,863	TOTAL (agree to Schedule V,	\$ 601,120	TOTAL (agree to Sch. V,	\$ 40,388	
(List each licensed administrator separately.)				line 22, col.8)		line 20, col. 8)		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**
				to Owners or Employees				
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees - Lancaster			\$ 199,200				Out-of-State Travel	\$
							In-State Travel	369
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 199,200					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount				Seminar Expense	2,103
Health Data Systems, Inc.	Data Processing		\$ 6,123				**Lancaster Allocation**	6,472
Power Software Development	Data Processing		1,344					
Blitz Comm Inc.	Data Processing		672					
Horizon Healthcare	Data Processing		765					
Computer MD, Inc.	Data Processing		1,600					
Ill. Business Communications	Data Processing		1,363					
Personnel Planners, Inc.	Payroll Tax Consultant		1,140					
Panarese & Panarese	Legal		7,364					
Winston & Strawn	Legal		712					
Schiff, Hardin & Waite	Legal		182					
Richard Peelo & Associates	Accounting		2,250					
Frost Ruttenberg & Rothblatt	Accounting		1,720					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	()
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 25,235				(agree to Sch. V,	
							line 24, col. 8)	\$ 8,944

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting and Decorating	1998	\$ 24,627	3	\$ 8,209	\$ 8,209	\$ 4,104	\$	\$	\$	\$	\$	\$
2	Painting and Decorating	Jul-99	26,214	3	4,369	8,738	8,738	4,369					
3	Painting and Decorating	Dec-99	13,669	3	2,278	4,556	4,556	2,279					
4	Painting and Decorating	Jan-00	4,221	3		703	1,407	1,407	704				
5	Painting and Decorating	Feb-00	10,169	3		1,694	3,390	3,390	1,695				
6	Painting and Decorating	Mar-00	606	3		101	202	202	101				
7	Painting and Decorating	Apr-00	2,192	3		365	730	730	366				
8	Painting and Decorating	Jul-00	241	3		40	80	80	41				
9	Painting and Decorating	Aug-00	592	3		98	198	198	98				
10	Painting and Decorating	Sep-00	2,588	3		431	863	863	431				
11	Painting and Decorating	Oct-00	8,123	3		1,354	2,707	2,707	1,355				
12	Painting and Decorating	Jul-02	4,909	3				819	1,636	1,636	818		
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 98,151		\$ 14,856	\$ 26,289	\$ 26,975	\$ 17,044	\$ 6,427	\$ 1,636	\$ 818	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 42,808 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 90,885
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

* Salary to Christopher Vicere was paid
as per details on page 7, line 2.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 19,134 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.